ICHLA

INversión 2010

Statewide Virtual Strategy Summit

Friday, September 24, 2010
9 a.m. to 2 p.m. EST

Bloomington
Fort Wayne
Gary
Indianapolis
South Bend

Mitchell E. Daniels, Jr., Governor

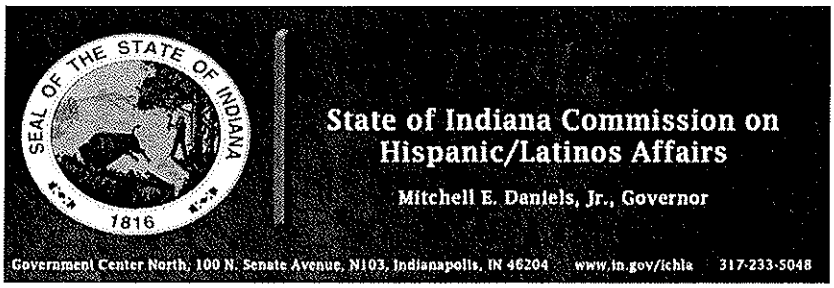
ABOUT ICHLA

MISSION

The Commission on Hispanic/Latino Affairs is a non-partisan state agency working toward economic, educational, and social equity, including promoting cooperation and understanding. The Commission identifies, measures, and reviews programs and legislation and researches challenges and opportunities affecting the Hispanic/Latino community. The Commission identifies solutions and provides recommendations to the governor and legislature.

VISION

The Commission on Hispanic/Latino Affairs will bring together community organizations, State agencies, municipal leaders, and local activists in a collaborative way to address the various challenges facing Hispanics and Latinos and to seek proactive, creative solutions that will have lasting impacts on the State of Indiana.



Dear community leader:

Thank you for joining us for the 2010 ICHLA INversión Statewide Virtual Strategy Summit!

The time you spend sharing your experiences and strategies with Hoosier leaders just like you from around Indiana is the first step in a comprehensive process to create a statewide framework for addressing some of the most pressing challenges facing our Latino communities. A thorough understanding of the types of initiatives underway in other municipalities and counties is a critical component to ensuring that our own strategies are as effective as they possibly can be.

Ronald Reagan said, "By working together, pooling our resources, and building on our strengths, we can accomplish great things." Well, he was right. Now more than ever, it is critical that we come together to share ideas, strategies, resources, and experiences in a way that benefits the people we are all serving on a daily basis.

Indiana is blessed to have an abundance of dedicated and effective community organizations led by committed people like you. You continue to give endlessly, asking little in return, because you understand the value of the role that you play in aiding those Latinos that need it most. It's time to take the next step in Indiana, to see the big picture and begin to truly think as a state about the best ways to address our challenges in a way that is efficient, measurable, and collaborative. Thank you for taking this step with us.

The Indiana Commission on Hispanic/Latino Affairs is honored to facilitate this meeting because we know how much Latino Hoosiers depend on you and the potential that exists for a truly comprehensive, statewide framework. Enjoy the conversations, and we're looking forward to following through in the months ahead!

Sincerely,

Danny Lopez
Executive Director

G. Herb Hernandez
Chairman

ICHLA INversión 2010 Statewide Virtual Strategy Summit
Friday, September 24, 2010

I. Breakfast/Registration/Meet-and-Greet (8:15am-9am)

II. Pre-Taped welcome remarks from the Governor (9am-9:05am)

III. ICHLA Welcome (9:05am-9:10am)
   a. The importance of building consensus
   b. Why statewide dialogue is important

IV. Topical Session #2 (9:10am-9:45am) – **Dr. David Marrero**
   a. Strategies for Promoting Healthy Eating Habits in Latino Families
      i. A synergistic and collaborative approach to curricular and extra-curricular education programs for healthy eating
      ii. A Case Study

V. Breakout session #1 (9:45am-10:20am)
   a. Groups work individually in their regions
      i. Regional challenges
      ii. Regional solutions
         1. What has worked/What hasn't worked
      iii. Regional information sharing
      iv. Regions develop list of consensus challenges and solutions

VI. General Session #1 (10:20am-11:10am)
   a. Each region presents their findings
   b. Statewide challenges/solutions are assembled and listed
   c. Q&A

VII. Lunch (11:10am-11:45am)

VIII. Topical Session #1 (11:45am-12:20pm) – **Dr. Magdalena Herdoiza-Estevez**

- a. Early Intervention Strategies for Lifting Graduation and Matriculation Rates
  - i. Understanding the main challenges
  - ii. A Case Study

IX. Breakout Session #2 (12:20pm-12:55pm)

- a. Groups work individually in their regions
  - i. Regional challenges
  - ii. Regional solutions
    1. What has worked/What hasn't worked
  - iii. Regional information sharing
  - iv. Regions develop list of consensus challenges and solutions

X. General Session #2 (12:55pm-1:45pm)

- a. Each region presents their findings
- b. Statewide challenges/solutions are assembled and listed
- c. Q&A

XI. Closing Remarks (1:45pm-2pm)

- a. What's next?
- b. Implementing a statewide model

Translating the Diabetes Prevention Program into the Community

The DEPLOY Pilot Study

Ronald T. Ackermann, MD, MPH, Emily A. Finch, MA, Edward Brizendine, MS, Honghong Zhou, PhD, David G. Marrero, PhD

Background: The Diabetes Prevention Program (DPP) found that an intensive lifestyle intervention can reduce the development of diabetes by more than half in adults with prediabetes, but there is little information about the feasibility of offering such an intervention in community settings. This study evaluated the delivery of a group-based DPP lifestyle intervention in partnership with the YMCA.

Methods: This pilot cluster-randomized trial was designed to compare group-based DPP lifestyle intervention delivery by the YMCA to brief counseling alone (control) in adults who attended a diabetes risk-screening event at one of two semi-urban YMCA facilities and who had a BMI ≥24 kg/m^2, ≥2 diabetes risk factors, and a random capillary blood glucose of 110–199 mg/dL. Multivariate regression was used to compare between-group differences in changes in body weight, blood pressures, HbA1c, total cholesterol, and HDL-cholesterol after 6 and 12 months.

Results: Among 92 participants, controls were more often women (61% vs 50%) and of nonwhite race (29% vs 7%). After 6 months, body weight decreased by 6.0% (95% CI=4.7, 7.3) in intervention participants and 2.0% (95% CI=0.6, 3.3) in controls ($p<0.001$; difference between groups). Intervention participants also had greater changes in total cholesterol (–22 mg/dL vs +6 mg/dL controls; $p<0.001$). These differences were sustained after 12 months, and adjustment for differences in race and gender did not alter these findings. With only two matched YMCA sites, it was not possible to adjust for potential clustering by site.

Conclusions: The YMCA may be a promising channel for wide-scale dissemination of a low-cost approach to lifestyle diabetes prevention.

(Am J Prev Med 2008;35(4):357–363)

Introduction

More than 60 million Americans have prediabetes, defined by impaired glucose tolerance (IGT) or impaired fasting glucose (IFG). People with prediabetes are at increased risk for developing diabetes,[1–5] cardiovascular events,[6–9] and other obesity-related adverse health outcomes. Because the prevalence of obesity is increasing in all segments of the population, the burden of prediabetes and diabetes will continue to escalate.[10] Identifying strategies to prevent diabetes on a national scale is indeed a public health priority.

The Diabetes Prevention Program (DPP) and other large randomized trials have demonstrated that a structured diet and physical activity intervention achieving modest weight loss in overweight adults with IGT can significantly reduce the progression to diabetes.[11,12] However, the DPP involved enrollment criteria and an intensive lifestyle intervention that are challenging to implement and sustain in busy healthcare settings.[13,14] In this context, there has been an ongoing need for real-world adaptations of the DPP lifestyle intervention that balance fidelity to DPP procedures with new design elements that optimize effectiveness, minimize cost, and improve sustainability.[15] Because healthcare settings have a limited capacity to offer intensive behavioral interventions,[16] success in achieving this goal is likely to require involvement by community organizations with greater expertise and resources for offering intensive lifestyle programs.

With exceptional reach into diverse U.S. communities and a long history of implementing successful health promotion programs, the YMCA is a capable community partner. Over the past 4 years, the YMCA of greater Indianapolis has participated with researchers

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at Indiana University School of Medicine (IUSM) to design, implement, and evaluate a group-based adaptation of the highly successful DPP lifestyle intervention. This pilot study was conducted to test the hypotheses that YMCA wellness instructors could be trained to implement a group-based lifestyle intervention with fidelity to the DPP model and that adults at high risk for developing diabetes who were assigned to receive this intervention could achieve changes in body weight comparable to the DPP.

Methods

Design

This study, known as Diabetes Education & Prevention with a Lifestyle Intervention Offered at the YMCA (DEPLOY), was a matched-pair, group-randomized pilot intervention trial involving two YMCA facilities in greater Indianapolis. Using data from a 2003 YMCA primary market area analysis of communities surrounding six local YMCAs, two facilities located in semi-urban communities with similar racial and socioeconomic characteristics were selected. These two sites volunteered to partner with the IUSM to implement and evaluate a community-based approach to identify and educate adults at risk for developing type 2 diabetes and to offer YMCA resources to help prevent the development of diabetes by promoting modest weight loss and increased physical activity. Before implementing this initiative, one of the two YMCA sites was randomly assigned to receive training and support for delivering a formal, group-based adaptation of the DPP lifestyle intervention at the YMCA facility. The Indiana University–Purdue University Indianapolis IRB approved the study protocol.

Participants

The goal of this study was to recruit participants who resembled DPP participants without imposing tests that are difficult to perform or sustain in a community setting. An approach was selected that combines a questionnaire and capillary whole-blood glucose testing to predict the risk for IGT or undiagnosed diabetes in a community setting.[17] This approach involved four major steps: (1) an invitation to adults with diabetes risk factors to attend a community-based screening and education event at the YMCA; (2) a determination of BMI; (3) completion of the 7-item American Diabetes Association (ADA) diabetes risk assessment[17,18]; and (4) collection of a drop of whole blood by finger stick to assess casual capillary blood glucose (CCBG) concentration for people with a BMI $\geq$24 kg/m^2 and an ADA risk score $\geq$10.

In three separate waves between August 2005 and May 2006, a 1-page letter was mailed to 7500 randomly selected households within approximately 5 miles of each YMCA facility. This letter introduced the concept of prediabetes and offered information about the effectiveness of lifestyle modification to prevent or delay the onset of diabetes. The flier listed common risk factors for prediabetes and encouraged adults who were affected by one or more of these risk factors to attend one of several diabetes risk-screening events at the nearest participating YMCA.[17,18]

All people attending the screening events were assessed for diabetes risk. CCBG was determined using a One-Touch Ultra handheld glucose meter.[19] People with a CCBG $\geq$200 mg/dL were informed that they were at high risk for diabetes and should see a healthcare provider immediately to undergo formal confirmatory testing and follow-up. People with an ADA risk score $\geq$10 and CCBG of 110–199 mg/dL (100–199 mg/dL if fasting $\geq$9 hours) were informed that they were at increased risk of developing diabetes and were potentially eligible for the study. These participants were referred to an onsite research assistant and were enrolled if they provided written, informed consent and were free of any comorbidity expected to limit lifespan to <3 years or to contraindicate the gradual adoption of light/moderate physical activity (e.g., a recent cardiovascular event, severe chronic obstructive pulmonary disease, advanced arthritis, poorly controlled hypertension).

Measures

All measures were collected by the IUSM research team during risk-assessment events held at the YMCA sites at baseline and after 4–6 and 12–14 months of study enrollment. The primary study outcome was percent change in body weight after 4–6 months. Body weight was measured using a calibrated, beam-balanced scale with participants wearing light clothing and no shoes. Secondary outcomes included changes in body weight at 12 months; changes in blood pressure, and point-of-care tests for HbA1c, total cholesterol, and HDL-cholesterol (HDL-c). HbA1c was assessed from a fingerstick capillary whole-blood sample using a DCA 2000 analyzer.[20,21] Total cholesterol and HDL-c were measured from capillary whole blood using a Cholestech LDX® lipid analyzer.[22,23] Blood pressures were assessed with an aneroid sphygmomanometer with appropriate-sized cuff and participants seated and relaxed for at least 5 minutes.

Intervention and Controls

Study participants were allocated to the DPP intervention or standard advice alone (controls) depending on the location of the YMCA at which they attended a screening event (i.e., group allocation). To avoid raising expectations about assignment to intervention or control groups at the time of enrollment, participants were told simply that the study would provide them with (1) access to additional resources from the YMCA to reduce diabetes risk through lifestyle modification, and (2) repeat diabetes risk testing with brief counseling again after 6 and 12 months.

The educational and motivational components of both interventions began during the screening events. All screening participants received personalized advice about their risk for developing diabetes, and those without contraindications were advised that modest weight loss (5%–10%) via caloric restriction and the gradual adoption of moderate physical activity (equivalent to brisk walking for 30 minutes daily) were generally safe and effective in preventing or delaying the onset of diabetes. Brief advice at the screening events typically took between 2 and 5 minutes and was supplemented by use of Small Steps, Big Rewards educational materials available from the National Diabetes Education Program (NDEP).[24,25]

Eligible screening participants who consented to enroll in the study met briefly with a YMCA employee before leaving

the screening event to learn about YMCA resources that might help them to reduce their risk for developing diabetes. At the intervention site, the YMCA employee discussed how to access the group-based DPP intervention. Enrollment in this program was highly encouraged but not a requirement for study participation. At the control site, the YMCA offered information about other existing wellness programs to help participants achieve modest weight loss through gradual lifestyle changes. Thus, participants in both the intervention and control groups received similar testing, brief counseling, NDEP materials, limited access to the YMCA to help with weight-loss attempts, and repeat testing and brief counseling again after 6 and 12 months of enrollment. However, only participants at the DPP intervention site were offered free-of-charge access to a new group-based diabetes prevention intervention.

Group-Based Diabetes Prevention Program

Participants at the intervention site who elected to participate in the new diabetes prevention program were assembled into groups of 8–12 people who could meet at a mutually agreeable time. Procedures for the group-based program were modeled closely after publicly available DPP materials,[26,27] with some adaptation to improve the sustainability of the program by the YMCA.[28] Briefly, the intervention core curriculum involved 16 classroom-style meetings focused on building knowledge and skills for goal setting, self-monitoring, and problem-solving. Program sessions lasted 60–90 minutes, and the entire core curriculum was delivered over 16–20 weeks. Goals upon completion of the program included a 5%–7% reduction in baseline body weight and 150 minutes per week of moderate-level physical activity similar to brisk walking. Although ongoing intervention activities are an essential component of successful weight maintenance,[29] this small pilot study was designed to demonstrate feasibility, so maintenance activities following the core curriculum sessions involved only monthly, large-group meetings at the YMCA, during which guest presenters discussed topics such as healthy restaurant eating and food shopping. Before implementing any of the program sessions, YMCA staff completed a structured two-and-one-half day group-instructor training curriculum administered by experienced DPP investigators. The YMCA selected instructor candidates based on their good communication skills and prior experience in group education or programming.

Several approaches were used to ensure that intervention sessions were delivered with fidelity to the DPP model. These approaches were based on similar strategies used during the DPP, and were developed by a training core of DPP project staff, YMCA personnel, and the principal investigator. Quality assurance began with the structured training and certification process described above, adapted from the DPP manual of operations. During implementation, group instructors had regular access to the DPP training team to discuss issues about lesson content, group moderation, or the medical questions of participants. The training core reviewed session logs (attendance and lesson checklists) submitted by the group instructors for any potential departure from the DPP lesson model. Fidelity, in this context, was discussed during the weekly meetings of the project team but was not assessed quantitatively during this study.

Statistical Analyses

Ordinary least squares multivariate regression was used to compare the between-group differences for percent change in body weight and for absolute change in HbA1c, systolic blood pressure, and total and HDL-c. Because this was a small pilot study involving only two matched YMCA sites, it was possible that between-group baseline differences in the two sampling populations could lead to confounding. Moreover, between-group differences in the baseline values of outcome variables could introduce bias from regression to the mean. To minimize these potential sources of bias, baseline values for the dependent variable were included in each regression model.[30] Because there was an 11% between-group difference in the percentage of participants who were men and a 22% difference in the percentage of participants of nonwhite race, sensitivity analyses were performed in which gender and (separately) race were added as a covariate to each model. Adding gender or race (white versus nonwhite) as a covariate did not change the magnitude or significance of any of the study outcomes, so only the results of models adjusted for baseline differences in the dependent variable are presented. All analyses were performed using SAS version 9.1 and include all participants who completed data collection, regardless of their level of intervention participation. As this was a pilot study involving only two YMCA sites, it was not possible to adjust SEs for potential clustering by YMCA site, and missing data were not imputed.

Results

Baseline Characteristics

A total of 535 adults were assessed during the YMCA-based diabetes risk screening events. Among all people screened, 143 had a high-risk ADA questionnaire and met the glucose-level criteria for the study. After the exclusion of 12 participants because of conditions that might preclude participation in a community-based physical activity program, 131 were eligible and 92 (70%) enrolled (Figure 1). At baseline, intervention and control participants were similar with respect to age, but control participants were more often female (61% vs 50%) and of nonwhite race (29% vs 7%) (Table 1).

Program Participation

Of the 46 participants in the intervention arm, 35 (76%) participated in at least one of the YMCA group lifestyle sessions. These 35 participants completed an average of 75% of the 16 core curriculum visits. Thus, the 46 participants allocated to the intervention arm attended an average of 57% (76% × 75%) of the maximum possible core curriculum sessions.

Outcomes at 4–6-Month Follow-Up

The 4–6-month follow-up visit was completed by 85% of intervention participants and 83% of controls. Participants who attended the follow-up evaluation were

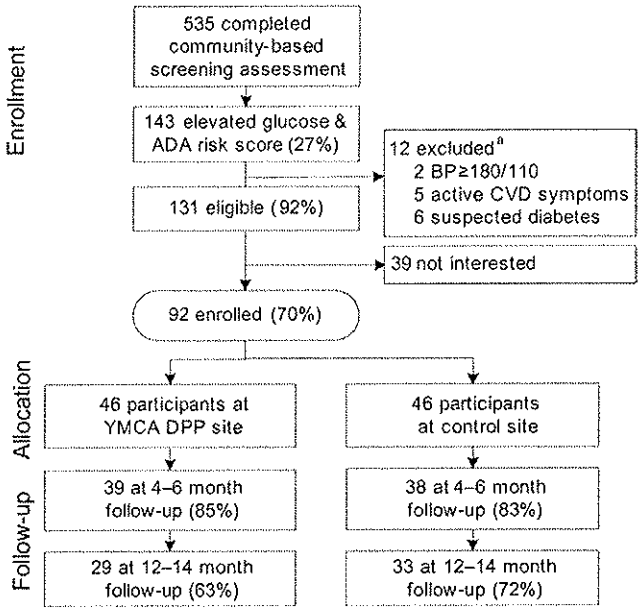

Figure 1. Trial flow
[a]One participant met more than one exclusion criterion.

not significantly different in age, gender, or race from nonrespondents to the follow-up evaluation. At the 4–6-month follow-up visit, there was a clinically meaningful and significant between-group difference in the primary outcome of percent change in body weight (Table 2). Compared to baseline levels, body weight decreased by 6.0% (95% CI=4.7, 7.3) in intervention participants and 2.0% (95% CI=0.6, 3.3) in control participants ($p<0.001$ for the difference between groups). This equated to a mean weight loss of 5.7 kg (12.5 lbs) for intervention participants and 1.8 kg (4.0 lbs) for controls. There was also a significant and clinically meaningful between-group difference in the change in total cholesterol concentration (−21.6 mg/dL intervention vs +6 mg/dL controls; $p<0.001$). There were no significant between-group differences in any of the other cardiometabolic risk measures over this relatively short period of follow-up.

Outcomes at 12–14-Month Follow-Up

At the 12–14-month follow-up visit, there was still a clinically meaningful and significant between-group difference in the primary outcome of percent change in body weight (Table 2). Compared to baseline levels, follow-up body weight decreased by 6.0% (95% CI=3.8, 8.3) in intervention participants and 1.8% (95% CI= +0.3, −3.9) in controls ($p=0.008$ for between-group difference). This equated to a mean weight loss of 5.7 kg (12.5 lbs) for intervention participants and 1.6 kg (3.6 lbs) for controls. There was also still a significant and clinically meaningful between-group difference in the change in total cholesterol concentration (−13.5 mg/dL intervention vs +11.8 mg/dL controls; $p=0.002$). Although none of the differences in remaining cardiometabolic risk measures reached significance, HDL-c appeared to exhibit a trend ($p=0.095$) toward greater elevation among intervention participants (+1.9 mg/dL) versus controls (−1.4 mg/dL).

Conclusion

This study found that YMCA wellness instructors can be trained to deliver a group-based DPP lifestyle intervention and achieve changes in body mass after 6 and 12 months that are comparable to the DPP study. This level of effectiveness was observed even in the context of a modest (57%) overall attendance level. This is the first study to demonstrate that the YMCA is a promising vehicle for the dissemination of the DPP lifestyle intervention into the community. In the DPP, 5 kg (about 5%) of weight loss was associated with a 58% reduction in incident diabetes.[31] In this pilot study, people at high risk for developing diabetes achieved and maintained a mean 6% reduction in baseline body weight and significant reductions in total cholesterol. Given these results, delivery of the DPP via the YMCA warrants further study as a model for the wide-scale dissemination of an evidence-based strategy to lower diabetes and cardiometabolic risk for millions of Americans with prediabetes.

This was a small pilot feasibility study, and it has some notable limitations. First, the study involved only two matched YMCA facilities and allocated participants by randomizing these sites to deliver a group-based DPP intervention or to offer only brief counseling and information about existing YMCA programs. This study design was chosen for two reasons: (1) the YMCA did

Table 1. Baseline participant characteristics[a]

Characteristic	Standard advice (n=46)	Group DPP (n=46)
Age (years)	60.1 (10.5)	56.5 (9.7)
Women (%)	28 (61)	23 (50)
Race/Ethnicity[b] (%)		
Hispanic	2 (4)	1 (2)
African American	9 (20)	2 (4)
White	32 (71)	43 (93)
Other	4 (9)	1 (2)
Comorbidity score[c]	3.6 (2.3)	2.6 (2.2)
Weight (kg)	90.9 (17.3)	94.5 (16.4)
BMI (kg/m^2)	30.8 (5.1)	32.0 (4.8)
HbA1c (mg%)	5.6 (0.5)	5.5 (0.5)
Total cholesterol (mg/dL)	178 (34)	197 (41)
HDL-cholesterol (mg/dL)	48 (16)	43 (14)
Systolic blood pressure (mmHg)	132 (15)	133 (18)
Diastolic blood pressure (mmHg)	81 (8)	82 (10)

[a]Mean (SD) unless otherwise specified
[b]Participants may have selected more than one category.
[c]Seattle Index of Comorbidity[38]; range 0–23, higher score reflects greater comorbidity
DPP, The Diabetes Prevention Program

Table 2. Main outcome effects[a]

Outcome	Standard advice	Group DPP	*p*-value
4–6 months	*n*=38	*n*=39	
% change in weight	−2.0 (−3.3, −0.6)	−6.0 (−7.3, −4.7)	<0.001
% change BMI	−2.3 (−3.7, −0.8)	−5.8 (−7.3, −4.4)	0.001
Change HbA1c (mg%)	−0.1 (−0.2, 0.01)	−0.1 (−0.2, 0.01)	0.96
Change total cholesterol (mg/dL)	+6.0 (−2.8, 14.8)	−21.6 (−29.9, −13.3)	<0.001
Change HDL-cholesterol (mg/dL)	+2.1 (−1.3, 5.4)	+1.1 (−2.1, 4.2)	0.68
Change systolic blood pressure (mmHg)	−2.3 (−6.1, 1.6)	−1.9 (−5.6, 1.9)	0.88
12–14 months	*n*=33	*n*=29	
% change in weight	−1.8 (−3.9, 0.3)	−6.0 (−8.3, −3.8)	0.008
% change BMI	−1.4 (−3.6, 0.8)	−6.7 (−9.1, −4.4)	0.002
Change HbA1c (mg%)	0.0 (−0.1, 0.2)	−0.1 (−0.2, 0.1)	0.28
Change total cholesterol (mg/dL)	+11.8 (1.3, 22.4)	−13.5 (−24.3, −2.8)	0.002
Change HDL-cholesterol (mg/dL)	−1.4 (−4.4, 1.3)	+1.9 (−1.0, 4.7)	0.10
Change systolic blood pressure (mmHg)	−2.7 (−8.0, 2.7)	−1.6 (−7.3, 4.1)	0.78

[a]Mean (95% CI)
DPP, The Diabetes Prevention Program

not feel comfortable declining program access to some participants at a single site when others (possibly a neighbor or close friend) would receive the program free of charge, and (2) it was desirable not to inform control participants that other individuals might receive a more-intensive lifestyle intervention. This minimized treatment contamination and some potential bias attributable to treatment awareness. However, group allocation may have increased the possibility of unmeasured confounding because it increased the probability of baseline differences between individual participants in the two treatment groups. In addition, it is possible that weight loss and other outcomes are correlated within neighborhoods (or YMCAs), and this could increase the probability that treatment differences were significant. Sensitivity analyses found that outcomes did not differ significantly with statistical adjustment for baseline differences in potential confounders such as gender and race. However, it was not possible to adjust for all potential confounders in this study or to control for the correlation of weight-loss outcomes within YMCA sites because this small pilot study involved only one site in each treatment group. Because the differences in weight outcomes were strongly significant ($p<0.001$ at 6 months), these findings clearly warrant further study of the group-based delivery of the DPP lifestyle intervention by trained YMCA wellness instructors.

Another interesting finding was the modest but significant weight loss observed by control participants. One explanation for this finding is that the study recruited and retained motivated people with an increased likelihood of achieving short-term weight loss with brief advice alone. Because 16% of the participants did not complete data collection at 6 months for the primary weight-loss outcome, the effectiveness of the intervention may have been over-estimated if weight loss was lower in nonrespondents. It is also possible that a community-marketing approach, followed by the formal testing of diabetes risk, brief activation by trained professionals, and follow-up for retesting after 6 and 12 months, may be sufficient to help some individuals with prediabetes to lose and maintain modest weight loss. Although brief counseling with limited follow-up alone is not typically sufficient as a strategy to maintain weight loss even in motivated volunteers,[29] it is possible that the knowledge of prediabetes risk is particularly activating, and that formal advice supplemented by NDEP materials can support lifestyle change in select individuals. Because even modest weight reduction translates into meaningful reductions in diabetes risk,[31] further research is needed to understand the impact of diabetes-risk perceptions on individuals' receptivity to brief lifestyle counseling.

Despite the clear effectiveness of an intensive lifestyle intervention to prevent the development of diabetes, there are no existing models for delivering such an intervention to a large and growing population of American adults with prediabetes. This study provides evidence that the YMCA could offer one solution for how to deliver a DPP lifestyle intervention in community settings and to achieve weight-loss levels that translate into considerable reductions in diabetes risk. The YMCA may also offer additional benefits for successful DPP translation because it is accessible to broad segments of the population and it sets fees for program access that are based on cost-recovery alone. Much of the difficulty in disseminating the original DPP lifestyle intervention has been the relatively high cost of one-on-one delivery by behavioral experts.[32] In this study, the hourly wage of YMCA group instructors was approximately one half that of behavioral experts in the DPP. Moreover, the group-delivery approach reduces overall personnel costs by an additional 50% by offering sessions to 8–12 participants simultaneously. Finally, the YMCA has a national policy to turn no person away due to inability to pay for membership or program access. Under this policy, the YMCA uses charitable donations

to subsidize access to programs by people in underserved areas and low-income households.

This study was not designed to compare different approaches for optimizing enrollment in a YMCA-based diabetes prevention intervention. However, the relatively low level of participation with community-based diabetes risk screening events verifies the findings from the DPP and other studies[33] that a household mailing approach alone may engage only a limited subset of people who are at risk for diabetes. Future research should assess and compare the use of multiple recruitment channels, in both healthcare and non-healthcare sectors, to optimize the reach of DPP translation activities in conjunction with low-cost intervention delivery by a community partner such as the YMCA.

By lowering the cost of and expanding the accessibility to diabetes-prevention services, the YMCA may serve not only to increase the number of individuals with prediabetes who have access to and can pay for evidence-based diabetes prevention; it may also provide a compelling model for health-plan reimbursement. This provides yet another compelling reason to develop and test novel strategies that link community-based program delivery with existing clinical services that could help to identify and activate more adults with prediabetes. Some health plans already pay for fitness facility access and other community wellness benefits, but short-term cost recovery and uncertainty about health benefits from these policies limits their sustainability.[34–36] If the YMCA can continue to develop and support a model for the formal training of program group instructors and can ensure the quality and consistency of the program as it has with other national lifestyle programs,[37] health plans may be more willing to pay the fees associated with a DPP intervention delivered at the YMCA for enrollees with prediabetes. In one prior prediction model, a health plan could pay 100% of the costs of the group lifestyle intervention as delivered in this study and recover all costs within 3 years (after which the plan would save costs each year from avoided health outcomes).[15] In this context, the costs and cost effectiveness of community-based models for DPP translation should be a primary focus of future studies.

There are currently more than 2500 YMCA facilities serving more than 10,000 rural, suburban, and inner-city communities in the U.S. alone. Given the encouraging benefits of group-based diabetes prevention in the YMCA on body weight and total cholesterol, combined with a potential for broad reach and cost effectiveness, the national dissemination of the DPP intervention in partnership with the YMCA provides hope in the battle against a growing national diabetes epidemic.

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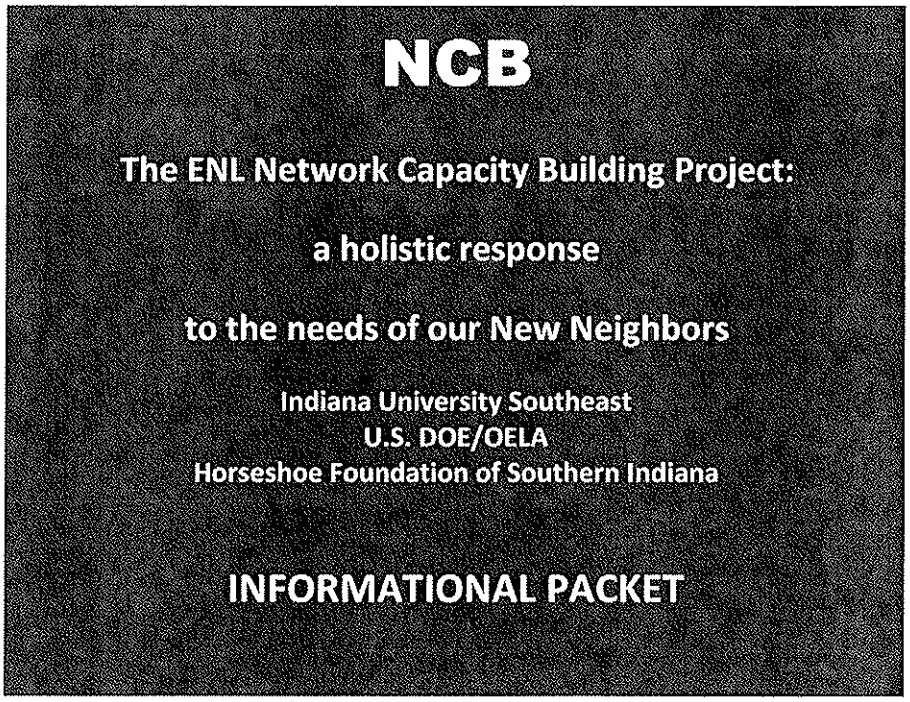
Virtual Strategy Summit

September 24, 2010



CONTENT:

- Statistics on English Language Learners in Indiana Public Schools
- Fundamentals on acquiring English as a second language: social and academic language
- Research-based conclusions on the importance of family literacy
- The importance of talking with your child
- Years 1-3 updates on the ENL Network Capacity Building project

English Language Learners in Indiana Public Schools

2008-09 Ranks 1-10:
Languages spoken by English language learners in Indiana public schools

Rank	Pupils	Percent
1 Spanish	36,586	79.7%
2 German (Amish)	1,234	2.7%
3 Arabic	680	1.5%
4 Burmese	660	1.4%
5 Mandarin(Sichuanese)	436	1.0%
6 Japanese	409	0.9%
7 Vietnamese	409	0.9%
8 Punjabi	396	0.9%
9 Chin	390	0.8%
10 Korean	378	0.8%
193 Other Languages	4,307	9.4%
Total	45,885	100.0%

Year	Number of "Limited English" Students
2008-09	45,885
2007-08	46,418
2006-07	42,727
2005-06	35,817
2004-05	31,956
2003-04	28,741
2002-03	22,589
2001-02	20,352
2000-01	17,194
1999-00	13,079

Public School Enrollment by Ethnicity, 2008-2009

White Non-Hispanic	Black Non-Hispanic	Hispanic	Multi-Racial	Asian	Native American	Total
785,082	127,836	71,532	43,711	15,275	2,827	1,046,263

Source: Indiana Department of Education

Acquiring English as a Second Language: Social and Academic Language

There are different timelines for learning social and academic language. Under ideal conditions, it takes the average second-language learner two years to acquire ***Basic Interpersonal Communication Skills (BICS)*** . BICS involves the context-embedded, everyday language that occurs between conversational partners. On the other hand, ***Cognitive Academic Language Proficiency (CALP)***, or the context-reduced language of academics, takes five to ten years to develop to a level commensurate with that of native speakers.

Over time, English language learners develop conversational English that appears fluent and adequate for everyday communication. However, they still struggle with CALP and have difficulty in areas such as reading, writing, spelling, science, social studies, and other subject areas where there is little context to support the language being heard or read. This "***BICS-CALP gap***" can lead teachers to falsely assume that the children have learning disabilities.

Ideally, we will support children's first languages and cultures, and encourage them to become fully proficient bilingual speakers. Not only will they perform better in school, but they will have a much greater chance of growing up to become successful citizens who are invaluable assets to our society and our economy.

Stage	**Characteristics of the Language Learener**	**Approximate Time Frame**
Preproduction	• Has minimal comprehension. • Does not verbalize. • Nods "Yes" and "No." • Draws and points.	0–6 months
Early Production	• Has limited comprehension • Produces one- or two-word responses. • Uses key words and familiar phrases. • Uses present-tense verbs.	6 months–1 year
Speech Emergence	• Has good comprehension. • Can produce simple sentences. • Makes grammar and pronunciation errors. • Frequently misunderstands jokes.	1–3 years
Intermediate Fluency	• Has excellent comprehension. • Makes few grammatical errors.	3–5 years
Advanced Fluency	The learner has a near-native level of speech.	5–10 years

Sources: *http://www.asha.org/public/speech/development/easl.htm*
Jane D. Hill and Cynthia L. Björk, *Classroom Instruction That Works with English Language Learners: Facilitator's Guide.* Alexandria, VA: ASCD.

Aprendizaje del Inglés como Segundo Idioma:

Lenguaje social y académico

El ritmo de aprendizaje para el lenguaje social es distinto del ritmo de aprendizaje del lenguaje académico. En condiciones idóneas, el aprendiz promedio de un segundo idioma tarde dos años en adquirir **destrezas de comunicación interpersonal básicas** (BICS-Basic Interpersonal Communication Skills). Estas destrezas entrañan el lenguaje diario de contexto integrado que ocurre entre interlocutores. Por otra parte, se tarda entre cinco y diez años en cultivar la **competencia lingüística académica cognoscitiva** (CALP-Cognitive Academic Language Proficiency) o lenguaje académico de escaso contexto, a un nivel equivalente al de los que estudian en su lengua natal.

Muchos de los estudiantes de inglés como segundo idioma se encuentran, por consiguiente, entre la espada y la pared. Puede que parezcan dominar de manera adecuada el inglés conversacional para la comunicación diaria. Pero aún tienen dificultades con la competencia lingüística académica cognoscitiva y en áreas como la lectura, la escritura, la ortografía, las ciencias, los estudios sociales y demás asignaturas en las que existe escaso contexto para respaldar el lenguaje que se escuche o se lea. Este fenómeno denominado la "**disparidad BICS-CALP**" (por sus siglas en inglés) lleva a los profesionales a suponer erróneamente que estos niños sufren discapacidades de aprendizaje del lenguaje.

Lo ideal sería que apoyáramos las lenguas y culturas natales de estos niños y los animásemos al mismo tiempo a dominar ambos idiomas. No sólo mejoraría así su aprovechamiento académico, sino que también tendrían mayor oportunidad de convertirse en prósperos ciudadanos que representaran una invaluable adición a nuestra sociedad y a nuestra economía.

Recursos en Internet

Colorin Colorado : www.colorincolorado.org Un sitio bilingüe para familias y maestros para ayudar a los niños a leer.

Guías para imprimir y usar:

Consejos de lectura para padres:
http://www.colorincolorado.org/guias/consejos
Consejos para los padres: Buen comienzo del año escolar:
http://www.colorincolorado.org/articulo/33155
Consejos para padres: Conferencias de padres y maestros:
http://www.colorincolorado.org/articulo/33954

More Free Parent Guides: http://www.readingrockets.org/guides/readingrockets#family

Free print guides created for parents, teachers, and many others who want to improve the reading achievement of children.

Family Literacy and Indiana's Hispanic and Latino Families
Families Read, Kids Succeed

The importance of family literacy has long been evident to educators. At the time Jim Trelease's Read Aloud Handbook was first published (1982), reading to a baby seemed somewhat ludicrous and unnecessary, but now it is widely recognized as important to the child's first steps toward literacy and the establishment of habits and routines within the family (Christenson & Sheridan, 2001). In an effort to provide current scientific evidence of the impact parental involvement can have in the academic career of a child, the National Center for Family Literacy, along with funding from the National Institute for Literacy, undertook a meta-analysis of current research literature (Senechal, 2008). The findings set out to give educators the most effective ways to enable parents to support their child's literacy development. The results, as reported by Darling & Westberg (2008), clearly showed all forms of parental involvement had a positive effect on the child's reading acquisition; however, the programs reporting the most impressive academic gains were those strengthening family literacy: "Interventions that actively serve parents seeking to improve their own literacy skills as well as support their children's learning, such as family literacy programs, are ideal settings for developing systematic training for parents to teach their children to read" (Darling & Westberg, 2004, p.776).

Furthermore, research indicates that the language being used by the parent during the early reading experiences is not of significance. Rather, it is the act of instilling literacy practices that makes all the difference (Colker, 2010; McBride-Chang & Kail, 2002). "The research clearly shows that children who come to school with experience in reading are less likely to encounter reading difficulties, regardless of the language in which they read or are read to (Riches & Genesee, 2007; Genesee & Riches, 2007; Reese et al., 2000; Snow, Burns & Griffin, 1998; Jackson & Wen-Hui, 1992). It is critical that families are made aware of this, as it is a concern to many families raising bilingual children that using the first language in the home might impede the acquisition of the second...." (Ballentyne, Sanderman, McLaughlin, 2008, p. 16). It is important to reassure parents that early reading activities and word play in the home language will not harm the child and will transfer from one language to another (Yopp & Stapleton, 2008). Indeed, studies have shown that there is no need to abandon the native language of a family when laying the foundation for a lifetime of literacy (Cummins, 2000; Baker, 2000; and Skutnabb-Kangas, 2000).

Since some Hispanic/Latino parents also have limited English skills, they believe they cannot effectively contribute to the education of their children, which is a myth that must be addressed. Reading and writing in the native language actually helps the second language acquisition (English in our case), and the use of the first language is also source of self-identity and pride in one's heritage. The United States is a nation of immigrants; this implies the co-existence of many languages and English. However, subtractive bilingualism is a detrimental process affecting many groups (Slavin & Cheung 2005; Cummins, 2000).

Talking With Children

Is it OK to speak to my child in my native language?
Talking to your child regularly lays the foundation for her language and literacy development. If you are most comfortable with your native language, you will be better able to communicate your feelings and ideas in that language. You can use words to label objects and describe what is happening as a way of teaching new words. You can recite rhymes and poems to develop her awareness of sounds. You can take turns talking about the day, things she notices, and books that you read together. By talking together, you teach your child about the purpose of language, while helping her express her feelings and ideas. And by speaking to your child in your native language, you also teach her about her culture and her identity.

But will speaking to my child in my native language make it harder for him to learn English when he goes to school?
Before children start school, they may be exposed to English on TV, in the playground, and in the print they see on cereal boxes and street signs. Children will learn a lot about English from the environment around them. If your child has also had some formal exposure to English, such as going to a playgroup in which English is the primary language spoken, then school can provide additional opportunities for him to learn the language. Children and teachers alike can serve as models, helping your child communicate what he knows and can do. You may even be surprised by how quickly he picks up the language as he plays and learns alongside other English-speaking children. If your child has had no formal exposure to English, he will use what he knows about his native language to learn English - which will be a major task. Talk with your child's teacher about your goals for your child, as well as any concerns you have.

My husband speaks to our daughter in English. I want to speak to her in my native language. Won't she get confused?
Learning even just one language is a complex process. But young children have the potential to learn more than one language. Again, what is most important is that you talk with your child in the language with which you are most comfortable, so you can have the types of conversations that promote your child's thinking and language development. It is also important to be a good language model and not mix up languages. That is, when talking with your child in English, don't mix in phrases and sentences from your native language. However, don't be surprised if your child uses words from both languages in one sentence. This is not a sign of confusion, but her current way of communicating what she wants to say.

If we only speak to our child in English, will he lose his ability to speak in native language?
Yes. You will therefore need to decide if you want your child to maintain his skills in your native language. Consider your long-term goals. If you and your family will not return to your home country, maintaining the native language may not be a priority. Also consider your family situation. If extended family members don't speak English, it will be important for your child to maintain his native language so he can communicate with people closest to him. Also consider how your child might feel about losing his native language and a sense of his cultural identity when he gets older.

My child insists on talking to me in English. How can I help her maintain her native language?
It requires time, persistence, and creativity. Some parents speak to their child only in their native language, even if their child responds in English. Other parents send their children to afterschool programs to learn more about their native language. You can also create routines to help your child maintain her native language - from outings with family members to watching movies and reading books in your native language.

My child is learning English as a second language. What should I do if he makes mistakes?
Avoid correcting your child or you might discourage him. A good way to help your child learn the "right" way to say something is to affirm what he says, using the correct pronunciation, sentence structure, or grammar. For example, if your child says, "The mail comed," you might say, "You're right. The mail came. Let's see if we got a letter from Grandma."

Is it OK to read books to my child in my native language?
Making a habit of reading together is important, no matter what language you read in. Reading to your child daily will increase her vocabulary, knowledge of the world, and understanding of story structure. If you are most comfortable with your native language, read to your child in that language. Then, you will be better able to read and talk about the stories as you read together. And by discussing stories with your child, you will help her develop language skills and better understand stories.

If I only read to my child in my native language, will he ever learn to read in English?
Yes, if he receives instruction. But reading aloud to your child in your native language will lay the foundation for learning to read in English. By building reading into your daily routine, your child will explore new concepts and ideas. At the same time, your child will increase his knowledge of print and books. He will learn how to open a book and that we read to the end of a line and return to the left to read another line. He will learn where a printed word begins and ends and learn the difference between a word and a letter. Research has shown that if children already know these important concepts about print in one language, they can apply them to reading in another language.

Should my child learn to read in English or our native language?
Learning to read is a complex process. Therefore, learning to read will be an easier task if your child is taught in the language she knows best. That way, she will not have to concentrate on learning to read and learning a new language at the same time. By learning to read in her stronger language, she will build the skills she needs to read in another language. The skills learned in one language will translate to the other language.

Source: *http://www.pbs.org/parents/readinglanguage/spanish/articles/multifamilies/reading.html*

http://www.colorincolorado.org/families

Conversar con los Niños

¿Es correcto hablarle a mi niño(a) en mi primer idioma?
Conversar con su niño regularmente es la base para el desarrollo del lenguaje y la lectura. Si a usted le es más fácil expresarse en su primer idioma, podrá comunicar mucho mejor sus sentimientos e ideas. Puede enseñarle nuevas palabras a su niño identificando objetos, describiendo acciones y situaciones. Puede recitar rimas y poemas para desarrollar el reconocimiento de los sonidos. Pueden conversar sobre lo ocurrido ese día, cosas que él (ella) haya notado y libros que lean juntos. Al conversar, usted le está enseñando a su niño(a) el propósito del lenguaje y a su vez le estará ayudando a expresar sus sentimientos e ideas. Al hablarle a su niño(a) en su primer idioma también le enseña sobre su cultura y su propia identidad.

¿El hablarle a mi niño(a) en mi primer idioma puede complicar su aprendizaje del inglés cuando vaya a la escuela?
Antes de que los niños comiencen la escuela, es probable que ya hayan sido expuestos al inglés a través de la televisión, en el patio de juegos y en las palabras impresas que ven en las cajas de cereales, como también en los letreros de la calle. Los niños aprenderán mucho inglés en el ambiente que los rodea. Si su niño(a) ha tenido una experiencia formal con el inglés, como el jardín maternal o preescolar, entonces la escuela le brindará oportunidades adicionales de aprenderlo. Otros niños al igual que los maestros, pueden servir de modelos para ayudarlo a comunicar lo que siente, sabe y lo que puede hacer. Puede que usted se sorprenda de lo rápido que lo aprende mientras juega con otros niños que lo hablan. Si su niño no ha tenido una experiencia formal con el inglés, usará lo que sabe en su primer idioma para aprender inglés; esto puede resultar una tarea laboriosa. Hable con su maestra sobre las metas que se propone para él (ella), así como las posibles preocupaciones que usted tenga.

Mi marido le habla en inglés a nuestro(a) niño(a). Yo quiero hablarle en mi primer idioma. ¿Esto podría confundirlo(a)?
Aprender un idioma de por sí ya es un proceso complejo. Pero los niños son capaces de aprender más de un idioma al mismo tiempo. Lo más importante es que usted le converse a su niño(a) en el idioma en el que usted se sienta más cómod0(a). Este tipo de conversaciones estimulan el desarrollo del pensamiento y del lenguaje. También es importante ser un buen modelo en la adquisición del lenguaje y no mezclar los idiomas. En otras palabras, cuando usted le esté hablando a su niño(a) en inglés, no mezcle frases y oraciones de su primer idioma. Pero no se sorprenda si su niño(a) usa palabras de ambos idiomas en una misma oración. Esto no es un signo de confusión, se trata de su forma actual de expresarse.

¿Nuestro(a) niño(a) puede perder la habilidad de hablar en su primer idioma si sólo le hablamos en inglés?
Sí. Tendrá por lo tanto que decidir si quiere que su niño mantenga sus habilidades en el primer idioma. Considere sus metas a largo plazo. Si usted y su familia no regresarán a su país natal, tal vez mantener el primer idioma no sea una prioridad [sin embargo, bilingüismo es mejor que monolingüismo]. Piense también en la situación de su familia. Si algunos miembros de su familia no hablan inglés, será entonces importante que su niño mantenga su primer idioma para poder comunicarse con ellos. También considere cómo se sentiría cuando sea adulto si perdiera su primer idioma y en cierto sentido su identidad cultural.

Mi niño(a) insiste en hablarme en inglés. ¿Cómo puedo ayudarle a mantener su primer idioma?
Requiere tiempo, persistencia y creatividad. Algunos padres hablan a su niño(a) sólo en su primer idioma, aún si el niño les responde en inglés. Otros, envían a sus niños a programas extraescolares en donde aprenden otro idioma. Usted también puede crear rutinas para ayudarle a mantener su primer idioma, como salidas con familiares, o ver películas, o leer libros en dicho idioma.

Mi niño(a) está aprendiendo inglés como segundo idioma. ¿Qué debo hacer si comete errores?
Evite corregir a su niño(a) o lo(a) desalentará. Una buena manera de ayudarle a aprender a decir algo de la forma "correcta", es afirmando lo que dice, usando la pronunciación, la estructura de la oración y la gramática correcta. Por ejemplo, si dice, "el correo viene ya" usted puede decir, "Tienes razón, el correo vino. Veamos si recibimos una carta de la abuela".

¿Está bien leerle libros a mi niño(a) en mi primer idioma?
Hacer un hábito de la lectura juntos es importante, no importa en qué idioma usted lea. Leer a su niño(a) en forma diaria aumentará su vocabulario, sus conocimientos del mundo y su comprensión de la estructura del cuento. Si usted se siente más cómodo(a) en expresarse en su primer idioma, lea a su niño(a) en ese idioma. De esta manera usted estará mejor preparado(a) para leer y hablar sobre los cuentos. Y al conversar sobre los mismos, la estará ayudando a desarrollar sus habilidades del lenguaje y a entenderlos mejor.

Si le leo sólo en mi primer idioma, ¿mi niño(a0 aprenderá alguna vez a leer en inglés?
Sí, si recibe instrucción formal. Pero el leerle en voz alta en su primer idioma será la base para que su niño(a) aprenda a leer en inglés. A través de la lectura diaria, explorará conceptos e ideas nuevas. Al mismo tiempo, aumentarán sus conocimientos sobre el lenguaje impreso y los libros. Aprenderá cómo abrir un libro y que debemos leer hasta el final de una línea y volver a la izquierda para leer la línea siguiente. Aprenderá dónde comienza una palabra impresa y dónde termina y reconocerá la diferencia entre una palabra y una letra. La investigación ha demostrado que si los niños ya han adquirido estos conceptos importantes sobre la lectura en un idioma, los pueden aplicar en otro idioma.

¿Mi niño(a) debería aprender a leer en inglés o en nuestro primer idioma?
Aprender a leer es un proceso complejo; por lo tanto, será una tarea más fácil si se le enseña en el idioma que entiende mejor. De esta manera no tendrá que concentrarse en aprender a leer y aprender un nuevo idioma al mismo tiempo. Al aprender a leer en el idioma que domina más, su niño(a) estará desarrollando las habilidades de lectura que necesitará en el otro idioma. Las habilidades aprendidas en un idioma se trasladarán al otro.

Fuente: *http://www.pbs.org/parents/readinglanguage/spanish/articles/multifamilies/reading.html*

http://www.colorincolorado.org/families

New Neighbors

Network Capacity Building

Responding to the ELL's Needs

Year 1-3 Update

The New Neighbors Network Capacity Building grant project, funded by the Office of English Language Acquisition, has seen tremendous growth and success during the first three years of its five-year plan. Not only have we met or exceeded our initial goals and expectations, but we have partnered with community organizations and individuals to maximize our impact and add new initiatives in successfully responding to the needs of the English Language Learners in Southern Indiana. These new and exciting initiatives include providing professional development activities to various school personnel, adding two new schools to our network, hiring instructional coaches, and, with the help of the Horseshoe foundation, opening a Bilingual Education Center for Adults (BECA).

Our successes and initiatives are too numerous to describe in detail in a brief update, but we have listed below highlights in the various categories:

National Recognition:

- The Association of Colleges for Teacher Education (AACTE) selected our project for its publication, ***Innovation and Reform in Teacher Preparation***, which collects models of best practices and was presented to the U.S. Congress at the AACTE's 5th Annual Day on the Hill, June, 2009. The focus of our entry was assessment of English language learners' improvement based on best practices.

K-12 Education:

- Professional development series are held annually for regular classroom teachers and school administrators. To date, 70 educators have been trained in English as a New Language (ENL) best practices.
- K-12 educators are completing coursework to receive ENL licenses. By August 2010, 22 teachers will have been licensed to teach English as a New Language.
- Bi-annual brainstorming/planning sessions are held with ENL teachers in each of the eight network schools.
- Monthly meetings are held with District Liaisons to organize, strategize, and coordinate efforts in the schools.
- Individualized instructional coaching is provided in 4 elementary schools and 4 secondary schools.

- Five teachers completed a series of SIOP training sessions (best practices for teaching ENL students in mainstream classrooms), conducted by their instructional coach.

- Over $38,200 of instructional resources in ENL best practices have been provided so far to the network schools.
- Teachers and administrators receive paid registration fees and mileage reimbursement to attend professional conferences in ENL best practices.

- Professional development workshops are conducted for school psychologists, speech and hearing clinicians, bus drivers, school secretaries, food services personnel, school nurses, nurse aides, and ENL instructional tutors/aides.

- Training and test score analysis sessions are held with our contractual research specialist for local school data personnel to maximize efforts toward understanding data for assessing the academic progress of English language learners.

- Students are treated to a field trip to the campus including a performance at the Ogle Center, a tour of the campus, and a meeting with international IU Southeast students and staff.

- Enrichment activities in reader's theater, art, and music are provided to the schools.

Higher Education:

- IU Southeast instructors in the School of Education are trained each year in ENL best practices and revise their syllabi to reflect those practices in their education classes. Pre and post surveys are conducted each year to track the results. Thus far, 18 faculty members have participated, totaling about 62% of faculty members of the School of Education.

- Faculty members are provided with extra funds for conferences and resources related to best practices for English language learners.

- Faculty members and network leaders are recognized presenters on the OELA project at numerous conferences locally, nationally, and internationally.

- Our project faculty submitted a formal input to the call by the Race to the Top initiative for a new USDOE assessment initiative.

Family Involvement:

- Consultants and interpreters are provided to the network schools at open houses, and at some parent-teacher conferences, and special events.

- The Horseshoe Foundation of Southern Indiana granted us an award for the creation of the Bilingual Education Center for Adults (BECA), which opened its doors in September 2009.

- Based on the success of BECA, the Horseshoe Foundation of Southern Indiana granted us a second award in June 2010 to provide bilingual literacy resources to families in our network schools. In 2010-2011 we plan to launch a more comprehensive parent cultural education program.

- BECA also holds parent workshops, one-on-one counseling, and parental assistance in special education, family literacy, school, and parenting issues.

- In 2010, we piloted more intensive family involvement programs within the network schools. Seven bilingual parent nights were held in which parenting and multicultural issues were discussed. In 2009, six additional bilingual sessions focused on parenting bicultural adolescents.

- To date, three computer classes and two nutrition and cooking classes have also been provided to parents in both Spanish and English. Our project provides personnel and materials for each of these workshops.

- Bilingual family literacy materials and children's books have been provided to over 100 parents in network schools.

- Parents are invited to the schools for health fairs, cultural nights, and performances.

Community Partnerships:

- We distribute bilingual DVD learning packets, entitled ***Grow Up Great,*** provided by PNC Bank, to our network schools and to individual parents attending our parenting meetings.

- Representatives from our project attend monthly meetings of the Hispanic Connection of Southern Indiana, partnering with them to provide for Latino families in our area.

- IU Southeast and Sister Cities of Louisville partnered to bring the Quitumbe Andean Ballet and Orchestra from Quito, Ecuador for a cultural exchange and performances for our network students and community-at-large.

- Network personnel and network parents participate in an annual seminar at the Center for Cultural Resources at the IU Southeast library focusing on the 40 Developmental Assets and English Language Learners. Action research has been developed on this topic.

- The New Neighbors project is exploring collaborating with the Indiana Commission on Latino Affairs.

- The community-at-large may learn more about our project on our specially-designed website: http://homepages.ius.edu/MHERDOIZ/newnpages/newneighbors.htm

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